SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

Quality Improvement Work Plan

Fiscal Year 2018-2019

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Quality Improvement Work Plan for
Objectives, Scope and Planned Activities for FY 2018-2019

Introduction

Quality Improvement and Continuous Quality Improvement are central tenants of how we work within the Santa Barbara County Department of Behavioral Wellness. It is a core business strategy and informs and influences all we do. This can be seen throughout the organizational structure of the department. Examples include the ongoing System Change efforts led directly by the Director, as well as the organization of the Office of Quality Care and Strategy Management (OQSM). The OQSM oversees the Quality Improvement Program and works to support continuous quality improvement throughout System Change efforts.

The Behavioral Wellness Quality Improvement (QI) Program is a Department of Health Care Services (DHCS) Mental Health Plan requirement. The QI Program coordinates performance-monitoring activities throughout the Mental Health Plan (MHP), including:

- Service delivery capacity
- Accessibility of services
- Timeliness of services
- Beneficiary satisfaction
- Service delivery system monitoring and analysis
- Service coordination with physical healthcare and other agencies
- Monitoring provider appeals
- Tracking and resolution of beneficiary grievances, appeals, and fair hearings, as well as provider appeals
- Performance improvement projects
- Consumer and system outcomes
- Utilization management
- Credentialing

The QI Program also assesses beneficiary and provider satisfaction and conducts clinical records review. The Mental Health Plan (MHP) QI Program is consulted in the contracting process for hospitals, as well as individual, group and organizational providers. The MHP QI Program has access to, and reviews as necessary, relevant clinical records to the extent permitted by State and Federal laws.

The Santa Barbara County Mental Health Plan Quality Improvement Committee embodies in its charter, the process of continuous quality improvement. The mission statement reflects the focus of review of the quality of specialty mental health services provided to beneficiaries and service recipients throughout the overall Behavioral Wellness system of care and recovery, focusing on continuous quality improvement. A very substantial aspect of that mandate relates to reviewing and selecting performance indicators and using data to evaluate and improve the performance of the Santa Barbara County Mental Health System of Care and Recovery.

Quality Improvement Committee Program Description

The QIC promotes the quality improvement program and supports recognition of both individual and team accomplishments. Its members are responsible for helping create a quality improvement culture. In this culture, employees use quality improvement principles and tools in their day-to-day work, with extensive support and guidance from leadership. The QIC reports to the Core Leadership Team and other management and staff work teams. Its executive sponsors play a critical role in maintaining leadership support.

The Quality Improvement Committee is responsible for:

1. Recommending policy decisions
2. Initiating, coordinating, reviewing and evaluating the results of Quality Improvement (QI) activities
3. Reviewing and evaluating performance improvement projects (PIPs)
4. Institution of needed QI actions
5. Guiding system-wide selection and application of quality improvement methods
6. Ensuring follow-up of QI processes
7. Documenting Quality Improvement Committee (QIC) meetings regarding decisions and actions taken
8. Developing the annual Quality Improvement Work Plan as well as the evaluation of the Work Plan.
9. Facilitation of routine committee activity reports

The Quality Improvement Committee (QIC) meets monthly throughout the year. Meetings are facilitated by the Quality Care Program Manager, who is a licensed practitioner and oversees the Quality Care Management Division. The QIC assigns and receives reports from QI sub-Committees and coordinates with the work of the Compliance Committee, reviews and evaluates the results of QI activities, recommends actions to appropriate departmental staff/divisions and ensures follow-up evaluation of actions. When appropriate, the QIC may recommend policy proposals for Santa Barbara County Mental Health Plan (SBCMHP) Executive Team consideration. On a quarterly basis, The QCM Manager presents the

activities and recommendations of the QIC activities to the SBCMHP Executive Leadership Team. QIC decisions and actions are memorialized by dated minutes that are signed by the QCM Manager.

The QI Committee (QIC) is composed of:

- Chief Quality Care and Strategy Officer (OQSM team)
- Research and Evaluation Program Coordinator (OQSM team)
- Santa Barbara County Mental Health Plan (SBCMHP) Chief of Compliance
- SBCMHP Medical Director
- SBCMHP Assistant Director of Programs
- Quality Care Management (QCM) Manager
- Utilization Review (UR) staff
- QCM psychiatrist
- The Department of Behavioral Wellness Regional Program Managers
- Management staff of Community Based Organizations (CBO's)
- Division Chief of the Department of Behavioral Wellness Management Information Systems
- Consumers and Family Members
- Patient Rights Advocates
- Consumer Empowerment Manager
- Peer Support Employees

The following active departmental sub-committees aid in the overall continuous quality improvement process and meet on a regular basis. These subcommittees, although not under the umbrella of the QIC, provide input, recommendations and reports to the QIC.

- **The Peer Action Team**: Addresses issues related to consumer and family volunteer and employment opportunities within the Department of Behavioral Wellness and other means through which the role of consumers and their families may participate in leadership, as well as ongoing activities of the department. (Meets monthly)

- **Community Based Organization Collaborative Meeting**: Children and Adult Community Based Organization Provider Meeting: Discusses various system issues, service delivery issues, documentation, DHCS review and contract issues. (Meets monthly)

- **Crisis and Acute Care Daily Triage Team**: Monitors and evaluates the flow and care provided to consumers who are using high levels of services, particularly inpatient, SNF, IMD, crisis residential, and other residential care, in order to identify trends, improve efficiency and effectiveness of care and suggest improvements. (Meets daily)

- **Information Systems Steering Committee**: Monitors implementation as well as areas of possible improvement in the MHP's electronic medical records, billing, and related information technology systems. The committee includes representatives from QI, MIS, Fiscal, Programs, and CBO's. (Meets monthly)

- **MIS/Clinician's Gateway User Groups**: Discusses Share/Care and Clinician's Gateway User concerns, suggestions and updates. (Meets quarterly)

- **Community Treatment and Supports**: Weekly joint provider meeting to prioritize and triage transfer and placement of clients into appropriate programs of the system. (Meets Weekly in each region)

- **Clinical Leads**: Weekly meeting which includes management and supervisors from all aspects of the system to discuss clinical/operation issues and programs. Collective problem solving and program planning for the clinical operations of the overall system. (Meets Weekly)

- **Data Management Meeting:** Meets every other week and includes representatives from various parts of the department including the MIS/IT Division Chief, Data and Evaluation team members and Leadership representation. System data reports are reviewed and refined prior to public posting. Review on how data collection occurs within the system and prioritization of data related system changes.

Evaluation of FY 17-18 Quality Improvement Committee Goals

For fiscal year 2017-2018, the SBCMHP QI Committee focused on five key areas. The Quality Improvement Committee tracked and trended data throughout the previous year and identified the five-areas of priority for quality improvement activities. Each goal has an assigned subcommittee that developed and implemented interventions designed to improve the specific function of the MHP.

Goal 1: Improve Client Service Experience and Satisfaction			
Objective	**Indicator**	**Result/Status**	**Point Person**
Implement DHCS client and family member consumer perception surveys (CPS); share results.	Compliance with DHCS CPS; ensure 100% offered opportunity to participate. Improve response rates and clinic participation Documentation – presentation of CPS results	Nov 2017 and May 2018	Susan- admin Dr K - analysis
Improve client and family member satisfaction with services	Analysis - Improved CPS results	Data analyzed annually	Dr K
Formulate system recommendations and monitor improvement activities	Demonstrations of data presentations at various committees; utilization of data/results by administrators for decision-making purposes	16/17 data analyzed Scheduling presentations	Dr K Leadership
Suggestion Box 1. Continuous implementation 2. Method for demonstrating action taken 3. Modification of form	 1. Monthly reports to QIC 2. Monthly reports to QIC 3. New form in English and Spanish created, shared at QIC and distributed to clinics	 1. Occurring monthly 2. Occurring monthly 3. Revised and in use	QCM
Conduct Network Provider and Recipient surveys to assess the value of services received through contracted providers	Demonstrated by agendas and minutes reflecting discussion and any recommendations/decisions made based on results	Sent Fall 2017	Susan
Identify and implement brief client satisfaction survey tools to be pilot-tested and then utilized throughout the	Instrument(s) selected or created; data collected and reviewed	Will be implementing TSP this fall for ADP; Suggestion Box/FIT tool	

system			
Ensure that all grievances and appeals are logged and include name, date and nature of problem	Grievance documentation; 100% of grievances received will be logged and responded to appropriately	Documented and reported monthly in Grievance Committee and to QIC	QCM

Goal 2: Improve Access to Care			
Objective	**Indicator**	**Result/Status**	**Point Person**
Track timeliness of access across the Mental Health Plan	Monthly QIC tracking; Quarterly QIC reports	Monitoring on a monthly basis Reporting to QIC Quarterly.	Ana: implement Dr K: analyze
Increase completion of Health History Questionnaire (to 50%) and PCP	Monthly QIC tracking; Quarterly QIC reports	Monitoring on a monthly basis HHQ: Q1-3 avg BeWell= 62% (chart review) PCP: Q1-3 avg = 27% (MIS)	Ana: implement Careena: chart review Dr K: analyze
Establish standards for access to SUD treatment	1. Contact to assessment; 2. Contact to MAT 3. Contact to detox	Will track per EQRO and establish internal goals after year 1	John: establish Dr K: analyze
Conduct routine test calls to 24/7 Access line (4 per month)	Documentation of test calls Monthly QIC tracking; Quarterly QIC reports	Monitoring on a monthly basis Reporting to QIC Quarterly Q1-3 avg = 3 per month	QCM
Utilize data from test calls for improvement of Access line	Test call information shared with managers/supervisors as indicated/appropriate	CR is sharing as needed with JH	QCM
Timeliness of access across the MHP and ODS systems; Tracking and utilization of data for system improvement.	Definitions specified for measurement of wait times to see an outpatient psychiatrist or ODS provider	Monitoring on a monthly basis Reporting to QIC Quarterly	Ana: implement Dr K: analyze

Improve attendance - children's assessment appointments	1. Track time between first contact to first assessment 2. Track no show rate	Tracking time to first appointment Tracking no shows	Ana: implement Dr K: analyze
Assess MIS/IT and make modifications necessary to track timeliness to SUD services	Changes made to MIS/IT	18 page self-assessment shared with JD and MR	John Marshall
Provider utilization of Access Contact Sheet for entry of calls and walk-ins	1. Train Providers 2. Monitor utilization	Plan changed: centralized Access	QCM
Improve identification of individuals with co-occurring mental health and substance use disorders who are served by the MHP	1. Documentation of training on co-occurring disorders 2. Documentation of SUD in EHR	1.Training – available in Relias 2. PDSA: % clients on Co-Occurring teams with secondary SUD diagnosis in SC Baseline = 24% September = 55%	Ana QCM

Goal 3: Improve Chart Documentation			
Objective	**Indicator**	**Result/Status**	**Point Person**
Improve % charts that have current: 1. Assessments 2. Treatment plans (Goal=90%)	1. % current (from MIS report) 2. % current (from MIS report)	PIP Monitoring on a quarterly basis through Dec 2017 (= 91.2% current tx plans)	Ana QCM
Provide monthly documentation trainings to improve frequency and quality of documentation	Provision and documentation of training	Trainings offered online instead in 17/18	
Increase the timeliness and quality of reviewed charts 1. within the Department 2. with CBO's	QCM report (monthly audit) % Chart that Meet Documentation Standards:	% Charts Meet Doc Standards Q1-Q3 Avg BeWell 17% Avg CBO 31%	Careena

Increase % of completed corrective action plans, following chart review feedback 1. within the Department 2. with CBO's (Goal=90%)	QCM report Past Month – %POC's Completed by Deadline)	% POC's Completed on Time: Q1 –Q3 Avg BeWell 44% Avg CBO 60%	Careena
Ensure the availability of a high quality documentation manual	Updated monthly; posted on line	1/18 waiting for Ana's approval/changes	QCM
Improve adherence to the team based care protocol and documentation of team based care planning	1. common diagnosis 2. work towards sameTx goals	Team based care progress note under development (JIRA)	Ana Careena Christine

Goal 4: Enhance Innovation, Collaboration and Integration			
Objective	**Indicator**	**Result/Status**	**Point Person**
Increase effectiveness of communication from the MHP administration	1. Survey staff 2. Implement new strategies, methods	Will be discussed after EQRO in new FY at Data Mtg	Leadership
Increase department and stakeholder knowledge of system updates through improved communication	Develop plan for implementation of strategies to increase effectiveness of communication	Brown Bag; Directors Report; Alice attending regional meetings.	Leadership
Improve how diversity data are captured within the EHR	Review and modify, as indicated, in CG: 1. Language 2. Ethnicity/race 3. Sexual orientation/gender identity	Changed made to screening, assessment forms	Yaneris MIS/IT
Investigate and address disparities in referrals, diagnosis and treatment for youth of color in the juvenile justice	1. Conduct surveys and focus groups with clients and families 2. Provide education to referral sources	1. Done 2. Done 3. Training under	Yaneris Jill Sharkey

system	3. Provide training for outpatient clinic based staff on implicit bias in clinical diagnosis	development	
Establish a system for 24/7 toll free access, with prevalent languages, for prospective ADP clients	ADP calls referred to Access line	All calls to Access	ADP QCM
Expand Access Screener staff, to advance the integration of SUD, MH and mental health and primary care services	Integrated, co-occurring capable (ADP/MH) Access line	Hiring 2 new staff; will provide training	ADP QCM
Finalize ASAM Screening and Assessment tools	Finalize forms in GC	Under development	ADP MIS/IT
ADP CBO's have access to the new Access Contact sheet in Clinician's Gateway	1. ADP CBOS's trained on access line and form 2. ADP CBO's utilization (track AOD related, Dept/CBO's access	Plan changed; centralized Access.	ADP MIS/IT

Goal 5: Ensure Quality of Contracted MHP Service Providers			
Objective	**Indicator**	**Result/Status**	**Point Person**
Routine review of contracted providers to ensure qualifications to provide specialty mental health services	1. Organizational providers receive re-certification every three years 2. Individual Network Providers receive re-certification every two years 3. Organizational providers who operate medication rooms are reviewed quarterly	1. QCM Tracking Log 2. QCM Tracking Log 3. QCM Tracking Log	QCM – Gizelle
Quarterly meetings with contract providers to assure adherence to medication room policy and procedures	Documentation of meetings/medication room review	December 2017, the lead on medication reviews was transitioned from QCM to Morgan, Laura, and Marianne; Reviews and POC reports on G drive	Morgan

Monthly site visits for all in-county contract providers to assure MHP regulatory requirements are met for MHP providers	Documentation of site visits	Occurring.	QCM

MHP Summary

Since the last QI Work Plan submission for FY 17-18, the MHP has experienced significant changes as a result of many developments, including major Systems Change efforts as well as changes and enhancements in overall program operations.

Highlights of significant MHP changes over the past year:

1. Provided a robust response to two community disasters; currently implementing FEMA grant
2. Hired a Pharmacist In-Charge for inpatient services
3. Continue to develop the Crisis System of Care, which included moving the Mobile/Triage Teams to a new facility adjacent to the CSU for improved collaboration and support
4. Established a new model for medical coverage at the PHF, which includes 16 hour medical shifts to provide support to other Crisis System services
5. Launched a new aspect to the Access Call Line which includes screening for crisis, alcohol and drug dependence, and sexual exploitation
6. Implemented Service Now platform for tracking IT Help Desk requests
7. Created an Informatics Manager position
8. Participating in regular coordination meetings with Medi-Cal Intermediary CenCal Health to improve integration of services and problem resolution for transitions of care
9. Enhanced collaboration with other Department partners such as Probation, District Attorney's Office, Public Defender, Sheriff, Public Health Department
10. Accomplished PIP Goals of Improved Assessment and Treatment Planning with Increased Client Engagement
11. Improvement in recruitment and hiring for key clinical positions resulting in decreased vacancy rates.
12. Clinic staff developed multiple PDSAs to improve no show rates, for example: Triage staff began contacting clients for appointment reminders over the weekend; and staff began calling clients who have missed an appointment to find out if there are any barriers, etc.

13. Increased use of the language line and in-person translation, since January of last year

Current initiatives of the department include:

1. Created an In-Patient Pharmacy that will also support the CSU as a satellite facility
2. Preparing for ODS implementation in the Fall of 2018
3. Implementing Pilot Project for establishing a Medication Support Clinic at the Lompoc Recovery Learning Center
4. Collaborating with the Public Defender and the Courts to create a specialized Incompetent to Stand Trial (IST) court
5. Improving care to clients through Reducing Ethnic Disparities (RED) committee
6. Collaboration with Sherriff deputies using CIT cards to help identify clients who have had contact with law enforcement and may need increased mental health services
7. Collaborating with Project Recovery in order to expedite clients being admitted into their detox program, reducing the risk for hospitalization
8. Developing a joint MOU for Continuum of Care Reform with Social Services and Probation
9. New CRT opening in the Fall

All of these efforts are consistent with the broad strategy of strengthening prevention, early intervention and outpatient programs to reduce the demand on our higher intensity and more expensive services. The goal is to be more balanced and increase capacity at all level of care with seamless and coordinated transitions. Behavioral Wellness aims to focus on being more welcoming, inclusive, transparent, accountable, responsive, recovery oriented, trauma informed, culturally competent, integrated, co-occurring and complexity competent.

FY 18-19 QI Work Plan Goals

Goal #1: Improve Access to Care

Intended Outcome:

- Utilizing data collected through the Access Contact Sheet and centralized Access screeners, strengthen the system to track timeliness of access across the Mental Health Plan and utilize data for system improvement
- Increase completion of Health History Questionnaire and increase the completion of the identification of client Primary Care Provider (located within the Health History Questionnaire) to allow improved access to healthcare (i.e. number of individuals who have access to their Primary Health Care Physician)
- Establish a reasonable minimum standard for access to treatment including length of time between initial contact and first substance use disorder treatment and first Medication Assisted Treatment (MAT) appointment for those with opioid and alcohol disorders

Objectives:

- Ensure all MH and SUD services are available in prevalent non-English languages
- Address disparities in referrals, diagnosis and treatment for youth of color in the juvenile justice system
- Track and analyze data on Access line wait times
- Continue to train Access screener staff on SUD and MH procedures; centralize/cross train all QCM staff to assure coverage of the Access line at all times.
- Finalize Access tools - ASAM Screening and Assessment
- Ensure Beneficiaries have access to information regarding safety resources for MH and SUD crises.
- Examine walk-in data and address as needed
- Conduct routine test calls to 24/7 Access line (4 per month) including test calls in non-English languages
- Make modification as needed to EHR to monitor Access to SUD services

Measurement:

- Number of test calls completed and logged each month
- Number of test calls completed in non-English languages
- Number of urgent calls received and logged each month
- Number of routine calls received
- Number of crisis calls received
- Track wait time to first appointment
- Provide information/training on use of Language Line. During site visits QCM will monitor availability of language services.

- Provide a refined series of implicit bias training which will focus on evaluation and diagnosis, specifically targeting the departmental needs rather than the formerly offered general training. Included in this refined training will be a training of trainer program as well as system training – both to begin in the fall of 2018.
- Data reports to measure completion of Access Staff training on SUD and MH procedures
- Measure use of ASAM screening and assessment forms by Access Team
- Monitor: information on overdose prevention and emergency services at clinics for beneficiaries to easily access. Include in CAP for providers to correct if this goal is not met during monitoring visit.
- Monitor data for walk in consumers and timelines to appointment

Key Work Groups:

- Peer Action Team
- Clinical Operations
- Office of Quality and Strategy Management

Goal #2: Improve Timeliness to Service

Intended Outcomes:

- Improve overall timeliness of access to care for beneficiaries in the MHP and ODS systems
- Ensure that the network of providers within the system is adequate for the needs of the beneficiaries within Santa Barbara County

Objectives:

- Track timeliness of access across the MHP and ODS systems and utilize for system improvement.
- Develop reporting mechanisms to assess access and timeliness to SUD
- Track no show rates and utilize for system improvement
- Begin tracking timeliness separately for the adult and child systems of care; follow up as needed for continuous quality improvement
- Make modification as needed to EHR to track timeliness to SUD services

Measurement:

- Track time from contact to assessment
- Track time from contact to first face to face
- Track time from contact to MAT
- Track time from contact to detox
- Track time from residential to follow-up
- Reports developed from data collected in the Access Screening Template and EHR

Key Work Groups:

- Community Based Organization Collaborative Meeting
- Crisis and Acute Care Daily Triage Team
- Clinical Leads
- Data Management meeting

Goal #3: Improve Quality of Care Provided to Clients

Intended Outcomes:

- Improve access to resources available to beneficiaries
- Increase client feedback and utilization of feedback
- Increase the timeliness and quality of reviewed charts within the Department of Behavioral Wellness
- Increase the timeliness and quality of reviewed charts within the contracted community based organizations.
- Increase the number of departmental staff who complete corrective action plans following chart review feedback
- Increase the number of community based organizational provider staff who complete corrective action plans following chart review feedback
- Ensure the availability of a high quality documentation manual, including current regulatory changes or interpretations, to ensure best clinical practice and documentation
- Improve adherence to the team based care protocol and documentation of team based care planning

Objectives:

- Ensure Beneficiaries have access to information regarding safety resources for MH and SUD crises.
- Discuss and strategize Suggestion Box and development of a tool to gather outpatient client feedback and client satisfaction (mirroring PHF satisfaction survey) and utilize client feedback in MH and SUD clinics/programs. Such a survey would occur on a randomized basis and be easily accessible to clients at clinic sites.
- Establish baseline and goals for SUD documentation –charts meeting documentation standards
- Quarterly site visits for all in-county contract providers to assure MHP regulatory requirements are met for MH and SUD providers
- CPS/TPS: Based on the data, formulate system recommendations and monitor improvement activities
- Ensure that all MH and SUD grievances and appeals are logged and include name, date and nature of problem
- Ensure that all SUD grievances are reported to the State quarterly and MH are reported annually

- Revise/Improve Health History Questionnaire
- Increase completion of PCP identification (to 90%)
- Utilize data from test calls for quality improvement of Access line
- Improve identification of individuals with co-occurring mental health and substance use disorders who are served by the MHP
- Maintain 90 % charts that have current assessments and treatment plans
- Increase percent of completed corrective action plans, following chart review feedback
- Increase the timeliness of reviewed charts within the Department and with CBO's
- Track progress on PIPs
- Make modification as needed to EHR to monitor quality of SUD services
- Routine review of contracted providers to ensure qualifications to provide specialty mental health services
- Continuous availability of documentation training on Relias

Measurement:

- Information on overdose prevention and emergency services at clinics for beneficiaries to easily access
- Client feedback log maintained by QCM
- QCM will conduct monthly chart review for approx. 5 % of charts, report to QIC monthly. Provide feedback and support to CBOs.
- Documentation of site visits
- Demonstrations of data presentations at various committees; utilization of data/results by administrators for decision-making purposes
- Grievance documentation; 100% of grievances received will be logged and responded to appropriately
- Grievance report
- Test call information shared with managers/supervisors as indicated/appropriate
- Continuous implementation of clinic-based satisfaction feedback/suggestion boxes and method for demonstrating action taken
- 100% of grievances are logged and responded to according to the Problem Resolution process (responding to the beneficiary)
- The MHP will review and respond to grievances at a system level to evaluate and make necessary changes and improvements in clinical practices. received will be logged and responded to appropriately
- Evidence of team-based care (communication and coordination of care) as evidenced by a common diagnostic reference
    - MD, case manager, and ShareCare
    - In chart review, will check for team based care planning through documentation
        - Treating Psychiatrist, case manager and ShareCare all reflect the same diagnoses
        - Evidence in clinical notes of work toward same treatment goals
- Reviewed charts will have 90% of assessments
- Staff will complete plans of correction 90% of the time
- Community based organizational provider staff will complete plans of correction 90% of the time
- Semi-Annual PIP reports

- Metric log, maintained by designated QCM team member for staff certifications, to track certification and recertification of MHP contracted providers

Key Work Groups:

- Clinical Leads
- Peer Action Team
- Clinical Documentation Subcommittee
- Clinical Operations
- Office of Quality Care and Strategy Management

Goal #4: Measure Outcomes and Utilize Data for System Improvement

Intended Outcomes:

- Make system improvements as a result/in response to CPS/TPS client satisfaction data
- Communicate with clients about results of satisfaction surveys
- Improve administration of the CPS survey including client participation/response rate
- Increase client engagement
- Collection of data on client satisfaction, which can be used to steer system operations. The Behavioral Health Commission and The Department of Behavioral Wellness Leadership Teams will be informed of client satisfaction data on a regular basis

Objectives:

- Implement DHCS Consumer Perception Surveys (CPS) - share results.
- Maintain "high" (>=3.5) client and family member satisfaction with services – CPS
- Improve response rates and clinic participation - CPS
- Plan for and implement SUD Adult client Treatment Perception Survey (TPS)
- Implement and monitor results of CANS and PSC-35
- Track and analyze data on levels of care
- Conduct Network Provider and Recipient surveys to assess the value of services received through contracted providers
- Develop reporting mechanisms to assess readmission to SUD Tx
- Analyze and distribute ADP provider outcomes on a quarterly basis
- Make modification as needed to EHR to monitor outcomes of SUD services
- Produce semi-annual and annual data reports that address access, timeliness, quality and outcomes

Measurement:

- Client perception survey
- Treatment Perception Survey
- Documentation – presentation of CPS results
- Improve response rate
- Demonstrations of utilization of survey results by administrators for decision-making purposes
  - ✓ The measurement for utilization will be demonstrated by agendas and minutes reflecting discussion and recommendations/decisions made based on the findings presented.
- CANS and PSC reports produced
- ASAM
- LOCRI
- Provider service recipient survey implemented
- Provider satisfaction survey data presented to QIC for the development of system improvement activity recommendations

Key Work Groups:

- Peer Action Team
- Clinical Operations
- Office of Quality Care and Strategy Management
- Collaborative Contract Provider Meetings

Addendum

Santa Barbara County Behavioral Health Care System

The Department of Behavioral Wellness (Santa Barbara County Mental Health Plan – SBCMHP) provides treatment, rehabilitation and support service to approximately 9,600 clients with mental illness and 4,453 clients with substance use disorders annually. Individuals needing assistance may call an Access Line, 888-868-1649, which is available to the community 24 hours a day, seven days a week. Services are provided throughout the system of care for Early Childhood Mental Health, Juvenile Justice Mental Health, children/adolescents and families, transition-age youth, and adults throughout the outpatient system, inpatient system and crisis services system. Services provided and teams assigned are based on the individualized level of need of the individuals being served.

Outpatient Services

The regional County-operated children's and adult outpatient clinics serve adults with serious and persistent mental illness, children with serious emotional disturbances who require long-term medication services, care coordination, case management and transition-age youth. Children and adults are also served through the provider network or contracted agencies. Aside from crisis services, access to services is provided regionally to ensure linkage to care in each individual client location. Screening and referral is provided by centralized Access screeners.

The SBCMHP maintains contracts with 10 individual in–county network providers and approximately 20 out-of-county providers. The MHP also uses contracted CBO's as organizational network providers. In addition, the MHP has contracts with CBO's for Crisis and longer term Residential Programs, Assertive Community Treatment Programs, Supported Housing Programs, Alcohol and Drug prevention and treatment programs, Recovery Learning Centers, Children's Wraparound, Therapeutic Behavioral Services, Intensive In-Home Services and Prevention and Early Intervention programs. For individual needs that cannot be met within the community setting, the MHP contracts with IMD's for adult care and contracts with out-of-county CBO's and residential programs as needed for children's care.

Inpatient Services

Adult consumers are served either through the 16-bed County-operated Psychiatric Health Facility (PHF) or through contracted psychiatric units at Aurora Vista Del Mar Hospital, however, this facility was burned in the Thomas Fire in December of 2017 at which time the facility could no longer be used. When all beds in these units are full, the MHP seeks the nearest bed available to the community in other contracted hospitals.

Children who need inpatient services are served through one of our contracted hospitals, usually Aurora Vista Del Mar, up through December 2017. In addition, to the extent that financial resources allow, the SBCMHP may contract with any hospital that has a bed available to provide inpatient services for either adults or children if such a contract is needed.

Crisis Services

Santa Barbara County Mental Health Plan has modified the previous system of care to improve urgent/emergent and routine access to care. Mobile Crisis Response teams and mobile Crisis Triage teams are located in Santa Barbara, Santa Maria and Lompoc and available throughout the county.

The Mobile Crisis program is responsible for 24/7 crisis response. This ensures that the response to all mental health crisis calls (to Crisis Services, Access, and 911), as well as mental health visits to Emergency Rooms are made by the Department of Behavioral Wellness clinical staff. This ensures both assessment of needs and connection to appropriate services. The Crisis Triage teams respond to urgent needs, helping-connect individuals with necessary supports and provide support during their time of crisis.

South County Crisis Services based in Santa Barbara. Crisis Services is staffed by a multi-disciplinary team of licensed professionals, including a psychiatrist, nurse, LCSWs, and MFTs, as well as unlicensed paraprofessional staff. Of the 20 FTE staff at Crisis Services South, 7 FTE staff members are bilingual. The Santa Barbara site is open from 8:00 a.m. to 6:00 p.m. Monday through Friday. Field-based services are provided to homeless individuals by designated homeless outreach staff from 8:00 a.m. to 7:00 p.m. Access and Mobile Crisis services are available 24 hours per day/7 days per week/365 days per year. A key role of the Crisis Services program is to provide services to individuals in psychiatric crisis, as well as to be the triage point for persons new to our system that are being discharged from psychiatric inpatient facilities.

North County Crisis Services based in Santa Maria is staffed by a multi-disciplinary team of licensed professionals including a psychiatrist, nurse, and MFTs, as well as unlicensed paraprofessional staff who provide interventions for clients in crisis. Of the 18 staff members, 8 are bilingual. North County Crisis Services is open 8:00 a.m. to 5:00 p.m. Monday through Friday, serving the same purpose as South County Crisis Services. Access and Mobile Crisis services are available 24 hours per day/7 days per week/365 days per year.

Lompoc CARES Mobile Crisis staff is physically located at the Lompoc County-operated adult outpatient clinic seven days a week during regular business hours. During all after business hour periods, the Santa Maria and Lompoc staff share crisis response duties due to lower demand, with response provided to crises in Santa Maria, Lompoc and the neighboring Santa Ynez Valley.

Crisis Residential Services: The MHP contracts for provision of Crisis Residential programs located in both Santa Barbara and Santa Maria regions of the county. The Santa Maria Crisis Residential program is located in the same building as the Santa Maria CARES program. The Santa Barbara program is located in very close proximity to the MHP campus. The programs both provide short-term 24/7 support and crisis stabilization services to consumers experiencing acute symptoms requiring more than outpatient care but less than acute hospitalization. These are voluntary programs and are supported by licensed and peer staff in both program.

Crisis Stabilization Unit: Located in the South County in Santa Barbara. The CSU offer short-term, rapid stabilization for individuals experiencing psychiatric emergencies. The program serves as an integral component within the overall crisis services system. Brief evaluation, linkage and referral to follow-up care are available. This unit is open 24/7 and offers safe, nurturing short-term, voluntary emergency treatment as an option for individuals experiencing a mental health emergency. Services available up to 23 hours.

Children's Crisis Services: Urgent and crisis needs for children are provided through the Safe Alternatives for Treating Youth (SAFTY) program. Casa Pacifica, a contracted organizational provider, operates the SAFTY program. This program works with children and families throughout Santa Barbara County on a short-term, intensive basis to help alleviate crisis situations and provide families with tools to prevent future

crises. This program operates on a 24/7 basis, and the staff are authorized by the County to write 5585 petitions with consultation from County staff.

In addition to 24/7 response, SAFTY provides expedited referrals to County-operated Adult and Children's Outpatient Clinics as well as short-term, in-home crisis resolution services.

Glossary of Terms

CBO – Community Based Organizational Provider

DHCS – Department of Health Care Services

EHR – Electronic Health Record

FTE – Full Time Equivalent (staff)

IMD – Institute for Mental Disease

MHP – Mental Health Plan

MIS/IT – Management Information Systems/Information Technology

OQSM - Office of Quality and Strategy Management

PIP – Project Improvement Plan

QCM – Quality Care Management

QI – Quality Improvement

QIC – Quality Improvement Committee

SBCMHP – Santa Barbara County Mental Health Plan

SNF – Skilled Nursing Facility

UR – Utilization Review